

CONSUMER PROFILE

Name Type	_____	Default	<input type="checkbox"/>
Last Name	_____	Name Prefix	Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/>
Middle Name	_____	First Name	_____
Generation	Jr. <input type="checkbox"/> Sr. <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V <input type="checkbox"/>	Name Suffix	Esq <input type="checkbox"/> MA <input type="checkbox"/> MD <input type="checkbox"/> PhD <input type="checkbox"/> RN <input type="checkbox"/>
Begin Date	_____	End Date	_____

ADDRESS

Address Type	_____	Default	<input type="checkbox"/>
Address Line 1	_____	Township	_____
Address Line 2	_____	State	_____
City	_____	County of Liability	_____
Zip Code	_____	E-mail Address	_____
County of Residency	_____	Begin Date	_____
Begin Date	_____	End Date	_____

TELEPHONE

Phone Type	_____	Default	<input type="checkbox"/>
Phone Number	(____) _____	EXT	_____
Begin Date	_____	End Date	_____

DEMOGRAPHICS

Gender	M <input type="checkbox"/> F <input type="checkbox"/> Other <input type="checkbox"/>	Marital Status	_____
Number of Dependents	_____	Residential Living Arrangements	_____
Legal Status	_____	Military Status	Active <input type="checkbox"/> Inactive <input type="checkbox"/> N/A <input type="checkbox"/>
Occupation Type	_____	Employer	_____
Employment Type	_____	Date Retired	_____
Citizenship	_____	Hispanic Origin	_____
Dependents under 18	_____	Dependents 18 & older	_____
Race	_____	Ethnicity	_____

CONSUMER PROFILE



P R / A D P / C B O 3 / 2 8 / 2 0 0 7

CONSUMER PROFILE

	Language _____	Speaking Proficiency High <input type="checkbox"/> Low <input type="checkbox"/> Med <input type="checkbox"/>	Reading Proficiency High <input type="checkbox"/> Low <input type="checkbox"/> Med <input type="checkbox"/>	Primary <input type="checkbox"/>	Preferred <input type="checkbox"/>
Language	Language _____	Speaking Proficiency High <input type="checkbox"/> Low <input type="checkbox"/> Med <input type="checkbox"/>	Reading Proficiency High <input type="checkbox"/> Low <input type="checkbox"/> Med <input type="checkbox"/>	Primary <input type="checkbox"/>	Preferred <input type="checkbox"/>
Education	Education _____	Institution _____	Degree _____		
Population	Population _____	Begin Date _____	End Date _____		

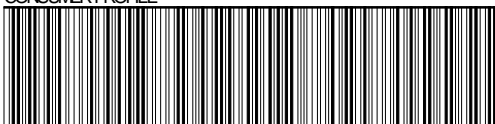
IDENTIFICATION

System of Care	_____		
Date of Birth	_____		
Social Security	_____		
Client Index Number	_____		
Alternative Consumer ID	_____		
Driver's License Number	_____	Driver's License State	_____
Mother's Last Name	_____	Mother's First Name	_____
Country of Birth	_____	State of Birth	_____
County of Birth	_____		
Deceased	<input type="checkbox"/>	Date of Death	_____
Notes	_____ _____		

CSI PERIODIC MENTAL HEALTH ONLY

Date Completed	_____	Date Reported	_____
Employment Status	_____	Axis V (GAF Score)	_____
Legal Status (Conserv/Court)	_____	Education	_____
Living Arrangement	_____	Developmental Disabilities	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Physical Health Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/Not Reported	Substance Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/Not Reported
Dependents under 18	_____	Dependents 18 or Older	_____

CONSUMER PROFILE



P R / A D P / C B O 3 / 2 8 / 2 0 0 7